DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second SOD

PRINTED: 09/15/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
SEP 18 2010
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185173	A. BUILDING _____ B. WING _____	09/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR NURSING AND REHABILITATION CENTER	200 NORFLEET DRIVE SOMERSET, KY 42501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on August 10-12, 2010. Deficient practice was identified with the highest scope and severity being at "F" level. An abbreviated standard survey (KY15099, KY15121) was also conducted at this time. KY15121 was unsubstantiated. KY15099 was substantiated with deficient practice identified.	F 900	F 164 1.Resident #1 was not affected by window curtain not being pulled and does not remember the event. 2.A one time audit of ten wound treatments and /or direct care will be completed by the Director of Nursing (DON), Education Training Director(ETD) and /or the Unit Manager(UM) to identify other residents that might be affected by this practice by 9/7/2010. 3.DON and /or ETD to re educate nursing staff regarding policy and procedure for resident privacy by 9/15/2010. DON and /or UM to audit 2 wound treatments by Licensed Personnel and 2 C.N.A's providing direct care daily x 5 d,then 3 x a week x 2 weeks ,then 1 x week x 2 weeks, beginning week of 9/16/2010 to ensure privacy is provided per Policy	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Spurgeon — TITLE: Adm. — (X6) DATE: 9/17/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Sep. 18. 2010 8:50AM No. 2911

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F 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide full visual privacy during a dressing change to the buttocks for one (1) of twenty (20) sampled residents (resident #1). Observations of wound care revealed the staff failed to pull the resident's window curtain, exposing the resident to any residents/visitors in the courtyard outside the resident's window. The findings include: Observations on August 11, 2010, at 1:45 p.m., revealed a Licensed Practical Nurse (LPN) entered resident #1's room to change a protective dressing on the resident's left buttock. The LPN closed the door to the room and pulled the privacy curtain around the resident's roommate. The resident was in the wheelchair and the LPN placed the resident in front of the sink. The LPN pulled the resident's pants and pull-ups down to expose the buttocks area and changed the dressing. The LPN did not close the window coverings. The resident was exposed to any residents/visitors that were in the facility's courtyard outside the resident's window. Interview on August 11, 2010, at 1:45 p.m., with the LPN performing the dressing change for resident #1 revealed the window coverings should have been closed to ensure the resident's privacy during treatment.	F 164	[illegible] 4.Quality Assurance Committee (Director of Nursing, Administrator(Adm), Social Services Director(SSD), Unit Managers, Education Training Director, Life Enrichment Director(LED), Dietary Manager(DM) and Maintenance Director) to review audit finding and revise as needed weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		

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F 225	Continued From page 2 ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	F225 1.Resident #1 physician was notified immediately upon patch being missing and patch was replaced immediately per order. Medical Director was notified regarding the reportable being late on 8/13/2010 by the Administrator. Resident #19 and Resident #20 were not affected by the date the final investigation was completed, the Medical Director was notified of the reportable being late on 8/13/2010 by the Administrator. 2.A one time audit of reportable incidents from 6/01/2010 thru 8/12/2010 was conducted by the Regional Director of Clinical Services(RDCS) on 8/12/2010 to identify if an other reportable had not been sent in timely and /or reported timely to ensure no other resident was affected.	

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F 225	Continued From page 3 by: Based on observation, record review, and interview, it was determined the facility failed to ensure that all allegations of abuse/neglect/mistreatment and misappropriation were investigated and reported to the appropriate state agencies timely. On July 21, 2010, the facility was informed a resident's Duragesic pain patch had been stolen (resident #1). The facility failed to report the allegation to the required agencies until July 23, 2010. The facility had two (2) additional investigations reviewed during the survey that had not been reported to the required state agencies timely as required. The findings include: A report was received from a family member of resident #1 that on July 21, 2010, the resident's pain patch had been stolen and the facility had not notified the family or the local law enforcement. Interview on August 10, 2010, at 4:25 p.m., with two family members of resident #1 revealed the family had arrived at the facility on July 22, 2010, to visit resident #1. The family members stated the resident's roommate informed them that there had been "a big commotion" the night before. According to the family members, they had not been notified by the facility of any problem the night before. The family members requested to speak with the Director of Nursing (DON) and were informed by the DON that resident #1's pain patch had been allegedly stolen the night before. The family asked the DON why they were not notified and were told the DON felt it would be better to speak directly with the family members when they came to visit. The family members	F 225	3.RDCS re educated the Administrator and DON on 8/12/2010 regarding policy and procedure for reporting and investigating abuse and /or neglect. ETD to re educate QA Committee members regarding policy and procedure for reporting and investigating abuse and /or neglect by 9/15/2010. RDO and /or RDCS to be notified of all alleged reports of abuse or neglect on the day it is reported to the Administrator and /or the Director of Nursing to	

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F 225	Continued From page 4 stated they had to request to speak to the DON and the DON had not tried to speak to them to inform them of the theft the night before. According to the family members, the resident had pain patches missing on other occasions but the facility had failed to inform them of the missing pain patches. An attempt was made to interview resident #1 on August 10, 2010, at 11:10 a.m., but the resident had no memory of the incident. An attempt was made to interview the roommate of resident #1 on August 10, 2010, at 11:10 a.m.; however, the roommate could not remember the date of the incident or what actually happened. The roommate began to describe "a robbery with three men dressed as women." It was determined the roommate was not a reliable historian. Interview on August 10, 2010, at 3:50 p.m., with the Certified Nursing Assistant (CNA) responsible for the care of resident #1 on July 21, 2010, revealed the CNA knew the visitor who was in the facility on July 21, 2010. According to the CNA, there had been allegations against the visitor related to missing narcotics in other facilities. The CNA informed the Charge Nurse and two nursing staff members checked the resident and the pain patch was in place. The CNA stated she went out for a break after the dinner meal had been served. When the CNA returned she checked resident #1 and the pain patch was missing. The CNA stayed with resident #1 and had another CNA report the missing pain patch to the Charge Nurse. Interview with the Registered Nurse (RN) who had been caring for resident #1 on July 21, 2010,	F 225	ensure it is reported timely, investigated timely and final investigation results sent to the appropriate agencies timely beginning 8/13/2010 x 60d. Administrator to maintain a log of reportables denoting day of report to appropriate agencies per policy and date the final investigation results sent to the appropriate agencies per policy beginning 8/15/2010. RDCS to review reportable log maintained by the Administrator bi monthly , beginning week of 9/7/2010. 4.Quality Assurance Committee to review all audit findings and reportable log entries for revision and /or recommendation weekly x 4 weeks then monthly, beginning week of 9/23/1010. 5.Date of Compliance 9/23/2010	

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F 225	Continued From page 5 revealed the RN had been informed that evening by one of the CNAs that there was a visitor in the facility that had a problem of taking pain patches from residents. The RN stated there was another occasion, he/she could not remember the exact date, that he/she was on duty and the family of resident #1 noticed the resident's pain patch was missing. The RN stated staff searched the resident's clothing and laundry but could not locate the missing pain patch. The RN notified the Unit Manager and replaced the pain patch. According to the RN, he/she and the LPN going off duty checked resident #1 at 6:30 p.m. on July 21, 2010, and the patch was in place. The RN stated approximately 30 minutes later the patch was discovered to be missing. The incident was reported to administrative staff by the RN in accordance with facility policy/procedure. Interview with the Unit Manager on August 10, 2010, at 4:15 p.m., revealed the Unit Manager had been working the evening of July 21, 2010. The Unit Manager stated she had been informed by staff that resident #1's pain patch had been stolen by a visitor to the facility. The Unit Manager stated she informed administrative staff of the incident. Interview with the facility Administrator on August 10, 2010, at 6:20 p.m., revealed the incident was reported to the Administrator by staff on July 21, 2010. The Administrator stated the family was not notified of the incident until the next day. The Administrator notified Adult Protective Services and the State Survey Agency on July 23, 2010. The Administrator stated the local police were notified of the incident on July 23, 2010. The Administrator stated the facility had not notified the State Survey Agency or Adult Protective	F 225		

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F 225	Continued From page 6 Services until July 23, 2010, two days after the incident. Interview on August 11, 2010, at 8:45 a.m., with the police department detective in charge of the case revealed the incident was reported to local law enforcement on July 23, 2010, by the resident's family member. The detective stated the police records indicated there were two reports filed related to resident #1 and missing pain patches and none had been reported by the facility. Review of the facility policy/procedure for Abuse/Neglect/Misappropriation (effective January 2007)revealed the facility was required to report all alleged violations and substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The policy required staff to notify the legal guardian, spouse, or responsible family members/significant other of the abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property immediately. The policy stated "immediately" meant as soon as possible, but ought not to exceed 24 hours after discovery of the incident. Review of two additional investigations conducted by the facility revealed an investigation related to an injury of unknown source for resident #19 for which the facility had not reported the results of the investigation within five days as required. The incident occurred on August 3, 2010, and the facility did not report the results of the investigation until August 10, 2010. A review of the investigation of resident #20's complaint of rough treatment by a Certified Nursing Assistant	F 225		

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F 225	Continued From page 7 was reported by the facility on August 4, 2010; however, the facility did not report the results of the investigation until August 10, 2010.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to develop a care plan for two (2) of twenty (20) sampled residents (residents #1 and #7). Resident #1 had been assessed to be at risk for the development of pressure areas due to remaining in the wheelchair throughout the day and the facility failed to develop interventions to address pressure relief for the resident. Resident	F 279	F 279 1.Res. # 1's care plan was updated to reflect individual needs on 8/11/2010 by the Interdisciplinary Team (DON, UM, LED,SSD, Facility Rehab Coordinator(FRC)). Res.#7 TED hose were applied on 8/11/2010 per order and physician was notified of TED hose not being on as ordered on 8/11/2010 by the DON. Her care plan and the CNA worksheet was updated to ensure that the	

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F 279	Continued From page 8 #1 was observed to have reddened and denuded areas to the buttocks and the facility had not developed a care plan to address the resident's prolonged time in the wheelchair. Resident #7 had a physician's order to wear Thrombo Embolic Deterrent (TED) hose. Resident #7 was observed to not have the TED hose in place and the facility had not developed a plan of care for the TED hose. The findings include: 1. Review of the medical record of resident #1 revealed the resident had been admitted to the facility on March 10, 2004, with diagnoses that included Alzheimer's dementia, chronic back pain, depression, anxiety, and hypertension. Review of the significant change assessment dated June 21, 2010, for resident #1 revealed the resident had been assessed to be moderately cognitively impaired. The facility had assessed the resident's activities of daily living needs to fluctuate from supervision to total assistance of one person. Review of the care plan for resident #1 dated as reviewed on June 22, 2010, revealed the resident had a problem area of not wanting to lie down during the day. Resident #1 had a previous history of a healed pressure ulcer to the left buttock. The care plan for resident #1 revealed the resident was noncompliant with the pressure reduction cushion. There were no documented interventions to address the resident's noncompliance with pressure relief. Observations of resident #1 on August 10, 2010, from 10:00 a.m. to 3:15 p.m., revealed the resident was sitting in the wheelchair throughout	F 279	TED hose are applied when out of bed per physician order on 8/11/2010. 2.A one time visual audit of all residents with orders for TED hose will be completed by the DON by 9/6/2010 to identify any other resident not wearing TED hose per order. A one time audit of Certified Nursing Assistant care plans will be completed by the DON/ETD and /or the UM to identify any resident who has orders for TED hose that is not reflected on the C.N.A. care plan by 9/3/2010. A one time visual audit of all residents to be completed to ensure all residents repositioned per individual schedule and identify any resident non compliant with turning and repositioning schedule will be conducted by the DON/ETD and /or the UM by 9/7/2010.	

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F 279	Continued From page 9 the day. The resident was able to move about the facility in the wheelchair without assistance. Observations of the resident's skin on August 11, 2010, at 1:45 p.m., revealed the resident to have a reddened area to both buttocks approximately three inches in width to each buttock. Four areas of denuded skin were observed on the resident's labial area which was reddened. The resident's upper thighs had reddened areas approximately five inches down the leg from the buttocks. The reddened areas were not blanchable and the resident stated the area was painful when pressed by staff. Review of the facility's policy/procedure for Turning and Repositioning Program (effective April 2009) revealed staff was required to turn and reposition residents every one to two hours when in the bed or wheelchair/geri-chair. Review of the daily nursing assistant care plan revealed the resident was to have a flotation cushion in the wheelchair and that the resident was on a turn schedule. Interview with the Director of Nursing (DON) on August 11, 2010, at 2:50 p.m., revealed the resident was noncompliant with getting out of the wheelchair during the day. The DON stated she was not aware of any care plan interventions to address the resident's noncompliance with pressure relief. Interview on August 11, 2010, at 3:15 p.m., with the Licensed Practical Nurse (LPN) responsible for the care of resident #1 on August 10 and August 11, 2010, revealed the resident was noncompliant with getting out of the chair for	F 279	3.ETD and DON to re educate nursing staff regarding policy and procedure for following physician orders, updating care plans to reflect individual needs , addressing non compliance on care plan and ensuring the C.NA care plan reflects resident care needs by 9/15/2010. DON/UM and /or ETD to audit 10 comprehensive care plans weekly x 2 weeks then 5 weekly x 2 weeks to ensure C.NA care plan reflect care needs , resident has any ordered appliance on, focusing on residents with orders for TED hose and any resident non compliant with turning	

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F 279	Continued From page 10 pressure relief and refused to go to bed to relieve pressure. According to the LPN, the resident used a pressure relief cushion in the wheelchair to prevent pressure ulcers. The LPN observed the resident's skin on August 11, 2010, and did not observe any problem areas. According to the LPN, the areas observed on the resident's buttocks were basically the same as always. 2. Observations of resident #7 on August 10, 2010, between 10:55 a.m. and 5:50 p.m., revealed resident #7 was in his/her room and in the dining room at meal times. During the observations no TED hose were observed on resident #7 as were ordered by the resident's physician. Review of resident #7's physician's orders dated July 2, 2010, revealed an order for TED hose to be placed on the resident's lower extremities in the morning and when out of bed and to be removed in the evening when returning to bed. However, a review of resident #7's comprehensive care plan last updated August 4, 2010, revealed TED hose had not been placed on the care plan as a need to be addressed when caring for the resident. Review of the Certified Nursing Assistant (CNA) daily care plan sheet, which is given to each CNA at the beginning of their shift to keep them informed of changes and what care each resident required, revealed the CNA care plan did not address resident #7's need for TED hose. Interview with resident #7's primary nurse on August 10, 2010, at 6:00 p.m., revealed the resident's care plan was updated when something changed pertaining to the care for the	F 279	and repositioning needs has interventions in place and the interventions are being followed beginning week of 9/22/2010. Interdisciplinary Team to review all comprehensive care plans to identify any resident with orders for TED hose is reflected and any resident non compliant with turning and repositioning schedule has interventions in place by 9/22/2010. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	185173	A. BUILDING _____ B. WING _____	C 08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 11 resident; however, the RN was unsure who updated the care plan. Interview with the facility's Corporate Consultant on August 10, 2010, at 6:12 p.m., revealed once a doctor's order was received a copy of the order was reviewed at a morning meeting, and then the CNA daily care plan was updated along with the comprehensive care plan to reflect all new orders and care needs that were to be addressed. According to the consultant, TED hose were never added to resident #7's care plan. Interview with the Director of Nursing (DON) on August 11, 2010, at 2:35 p.m., revealed the DON was unsure why the order for the TED hose for resident #7 had not been placed on the comprehensive care plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1.Res. # 12 was placed on 15 minute visual checks when out of bed to ensure that his order for "nothing by mouth" is followed. The physician was notified immediately on 8/11/2010 that resident had drunk water, new orders were obtained and followed, care plan updated to reflect individual needs and physician orders. Resident #12 has had no complication related. 2.A one time audit of all residents with NPO orders was completed by the DON/UM and ETD to identify if any resident had the potential to be affected and the plan of care was appropriate on 9/2/2010.	

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F 280	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to periodically review and revise the comprehensive care plan for one (1) of twenty (20) sampled residents (resident #12) to address the resident's noncompliant behavior related to consumption of liquids. The resident had a gastrostomy tube feeding and a physician's order to receive nothing by mouth related to the resident's difficulty swallowing. Resident #12 was observed during the survey to drink liquids from other residents and the facility had no interventions in the plan of care to prevent the resident from obtaining liquids. The findings include: Observations of resident #12 on August 11, 2010, at 10:30 a.m., revealed the resident had been transported in the wheelchair by a staff member to the hallway. Resident #12 entered another resident's room and drank from the water pitcher in the room. Staff removed the resident from the room after approximately two minutes and placed the resident back into the hallway and removed the water pitcher. Observations on August 11, 2010, at 5:40 p.m., revealed resident #12 to be in bed. The resident's overbed table was located over the resident's lap and within the resident's reach. The overbed table contained two paper cups. One paper cup was empty and the other cup contained approximately 60 milliliters (ml) of clear liquid. The resident stated, "They say I'm not supposed to have water and they leave it	F 280	3.ETD re educated nursing staff regarding policy and procedure for following physicians orders, following plan of care, development of comprehensive plan of care and NPO status on 9/07/2010. DON to re educate SSD regarding policy and procedure for addressing behaviors and comprehensive plan of care development by 9/8/2010. DON/ETD and /or UM to review behaviors and all residents with NPO status 5x week x 1 week , then 3 x week x 2 weeks, then 1 x week x 2 weeks beginning week of 9/16/2010 to ensure behaviors are addressed on plan of care, C.N.A care plan is current and correct , focusing on any behavior relating to food/fluid intake. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	

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F 280	Continued From page 13 here." Review of the physician's orders for resident #12 revealed an order for the resident to receive nothing by mouth due to difficulty swallowing. Review of the nursing notes for resident #12 dated November 10, 2009, February 1, 2010, May 30, 2010, and July 2, 2010, revealed documentation of the resident wandering into other residents' rooms and drinking from the other residents' water pitchers. Review of the annual comprehensive assessment for resident #12 dated April 30, 2010, revealed the resident had been assessed to have a history of sneaking water when the resident found an opportunity. Review of the Care Plan for resident #12 developed on January 28, 2010, and dated as reviewed on June 24, 2010, revealed the facility had identified the resident to have behaviors of wandering in and out of other rooms looking for fluids to drink. There were no interventions in place to address the resident's behavior. Resident #12's respiratory care plan identified a problem area of the resident entering other resident rooms and going to the water fountain to drink water. The facility had identified an intervention on February 3, 2010, to remind the resident not to drink water. There was no evidence the facility had revised the care plan for resident #12 when the interventions in place on February 3, 2010, were ineffective. Interview on August 12, 2010, at 1:10 p.m., with the Education/Training Registered Nurse (RN) revealed the resident "sneaked" around and obtained water to drink. The Education/Training RN stated the resident had the freedom to move around the facility. According to the	F 280		

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F 280	Continued From page 14 Education/Training RN, staff checked on the resident during routine rounds. Interview on August 12, 2010, at 1:20 p.m., with Certified Nursing Assistant (CNA) #2, revealed resident #12 was not to receive water. CNA #2 stated the resident would enter other residents' rooms and drink from their water pitchers or obtain water from the sink in the resident's room. CNA #2 stated staff checked the resident frequently when the resident was up but there was no set schedule.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet professional standards of quality by failing to follow physician's orders for one (1) of twenty (20) residents (resident #7). Resident #7 had a physician's order to apply TED (thrombo embolic deterrent) hose in the morning and remove them at night. However, observations on August 10, 2010, revealed resident #7 was not wearing TED hose. The findings include: Observations on August 10, 2010, between 10:55 a.m. and 5:50 p.m., of resident #7 in the resident's room and in the dining room revealed the resident was not wearing TED hose on the resident's lower extremities.	F 281	F281 +-+-*- 1.Res. # 1's care plan was updated to reflect individual needs on 8/11/2010 by the Interdisciplinary Team (DON, UM, LED,SSD, Facility Rehab Coordinator(FRC)). Res.#7 TED hose were applied on 8/11/2010 per order and physician was notified of TED hose not being on as ordered on 8/11/2010 by the DON. Her care plan and the CNA worksheet was updated to ensure that the TED hose are applied when out of bed per physician order on 8/11/2010. 2.A one time visual audit of all residents with orders for TED hose will be completed by the DON by 9/6/2010 to identify any other resident not wearing TED hose per order. A one time audit of Certified Nursing Assistant care plans will be completed by the DON/ETD and /or the UM to identify any resident who has orders for TED hose that is not reflected on the C.N.A. care plan by 9/3/2010	

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F 281	Continued From page 15 Record review revealed a physician's order dated July 12, 2010, for resident #7 "to have TED hose placed on lower extremities in a.m. when out of bed and removed in p.m. when returning to bed." Interview with three certified nursing assistants (CNA) on August 10, 2010, between 3:30 p.m. and 4:00 p.m., revealed the CNAs were unaware resident #7 required TED hose. Interview with resident #7's primary registered nurse (RN) on August 10, 2010, at 6:00 p.m., revealed it was the aides' responsibility to ensure residents' TED hose were applied. The RN stated the night shift RN should have told the aides which residents were supposed to wear TED hose. Interview further revealed the RN had not informed the CNA to put TED hose on resident #7. Interview with the Unit Manager on August 10, 2010, at 6:08 p.m., revealed it was the responsibility of the aides to place TED hose on residents. Interview with the regional program consultant on August 10, 2010, at 6:12 p.m., revealed once a physician's order was written a copy of the order went to the morning meeting where it was discussed and the order was placed on the aides' daily care plan. However, interview further revealed the order for resident #7 to have TED hose was never transferred to the aides' daily care plan for them to know that resident #7 required TED hose.	F 281	C.N.A. care plan by [illegible] A one time visual audit of all residents to be completed to ensure all residents repositioned per individual schedule and identify any resident non compliant with turning and repositioning schedule will be conducted by the DON/ETD and /or the UM by 9/7/2010. 3.ETD and DON to re educate nursing staff regarding policy and procedure for following physician orders, updating care plans to reflect individual needs , addressing non compliance on care plan and ensuring the C.NA care plan reflects resident care needs by 9/15/2010. DON/UM and /or ETD to audit 10 comprehensive care plans weekly x 2 weeks then 5 weekly x 2 weeks to ensure C.NA care plan reflect care needs . resident has any ordered appliance on, focusing on residents with orders for TED hose and any resident non compliant with turning and repositioning needs has interventions in place and the interventions are being followed beginning week of 9/22/2010. Interdisciplinary Team to review all comprehensive care plans to identify any resident with orders for TED hose is reflected and any resident non compliant with turning and repositioning schedule has interventions in place by 9/22/2010. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. Date of Compliance 9/23/2010	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

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F 282	Continued From page 16 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services for one (1) of twenty (20) sampled residents in accordance with the written plan of care. Resident #7 was care planned to have a safety belt check every thirty (30) minutes and released every two (2) hours for ten (10) minutes and as needed for personal care. However, observations revealed staff did not release the safety belt. Interview with staff revealed staff was not aware of the care planned need to remove the safety belt. The findings include: Observations made on August 10, 2010, at 10:55 a.m., 11:05 a.m., 11:23 a.m., 11:42 a.m., 11:48 a.m., 11:56 a.m., 12:03 p.m., 12:12 p.m., 12:46 p.m., 5:10 p.m., 5:50 p.m., and 6:20 p.m., and on August 11, 2010, at 9:00 a.m., 9:40 a.m., 10:20 a.m., 11:00 a.m., 11:20 a.m., 1:00 p.m., 3:00 p.m., 3:30 p.m., 4:05 p.m., and 4:35 p.m., revealed resident #7 was in a wheelchair with an alarm safety belt fastened around the resident. The resident was observed to be out of her wheelchair on August 10, 2010, from 1:57 p.m. until 3:00 p.m., during which time the resident was in bed. Record review for resident #7 revealed a written care plan dated November 18, 2009, which required the lap belt be checked every 30 minutes	F 282	F 282 1.Resident # 7 has had no changes related to restraint being on 8/10/2010 and 8/11/2010, and was out of wheelchair to be toileted several times on 8/10/2010 and 8/11/2010.Medical Director was notified that restraint was not released per order 9/3/2010 by the DON. 2.DON and UM completed a one time audit of physicians orders to identify other residents with orders for restraints to ensure plan in place for release per policy 8/30/2010.	

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F 282	Continued From page 17 and released every two hours for ten minutes and as needed for personal care. Interview on August 11, 2010, between 10:30 a.m. and 3:30 p.m., revealed four CNAs were unaware of the care planned need to release resident #7's safety belt every two hours for ten minutes. Interview on August 10, 2010, at 5:43 p.m., with the primary Registered Nurse (RN) for resident #7 revealed the RN was unaware of the need to release the safety belt every two hours for ten minutes. Interview further revealed the RN believed since resident #7 could take the safety belt off there was no need for staff to assure it was removed every two hours. Interview on August 11, 2010, at 5:10 p.m., with the primary RN assigned to resident #7 revealed the RN was unaware of a written care plan to release resident #7's safely belt. Thus the RN had not made the CNAs aware of the need to release the safety belt.	F 282	3.ETD to re educate nursing staff regarding restraint policy and procedure , ensuring plan of care reflects when to release and C.N.A care plan identifies what type of restraint and when to release by 9/7/2010. DON/ETD and UM to audit all residents with restraints to ensure plan of care is followed and restraint is released per order 5x week x 2 weeks then 2 x week x 2 weeks beginning week of 9/15/2010. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		

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F 314	Continued From page 18 by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents who were at risk for developing pressure ulcers and/or had a history of pressure ulcers received the necessary treatment/services to prevent new pressure ulcers from developing for one (1) of twenty (20) sampled residents. Resident #1 was assessed to be at risk for skin breakdown but was noncompliant with getting out of the wheelchair for pressure relief. The facility failed to develop interventions to address the resident's noncompliance and provide pressure relief for the resident while in the wheelchair. The findings include: Review of the medical record of resident #1 revealed the resident had been admitted to the facility on March 10, 2004, with diagnoses that included Alzheimer's dementia, depression, chronic back pain, hypertension, and anxiety. Review of the care plan for resident #1 dated as reviewed on June 22, 2010, revealed the resident had a history of not lying down during the day and that the resident was noncompliant with the pressure reduction cushion. The resident had a history of a healed Stage II pressure sore to the left buttock that had been resolved on July 7, 2010, and the resident was frequently incontinent of urine. There were no interventions developed for the resident's noncompliance with pressure relief or for ensuring the resident had opportunities to be out of the wheelchair during the day. Observations of resident #1 on August 10, 2010, from 10:00 a.m. to 3:15 p.m., revealed the resident was sitting in the wheelchair throughout	F 314	F 314 1. Res. # 1's care plan was updated on 8/11/2010 by the Interdisciplinary Team to reflect individual needs and ensure non compliance is addressed. Resident #1 physician was notified of skin status on 8/11/2010 , new orders noted. Area on skin identified is resolved. 2.A one time skin audit of all residents was conducted by the RDCS , ETD, DON and UM to identify any area of skin impairment , not previously identified on 8/12/2010.	

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F 314	Continued From page 19 the day. The resident was able to move about the facility in the wheelchair without assistance. Staff did not reposition the resident or take the resident to his/her room to be out of the wheelchair. Observations of the resident's skin on August 11, 2010, at 1:45 p.m., revealed the resident to have a reddened area to both buttocks approximately three inches in width and four inches in length to each buttock. Four areas of denuded skin were observed on the resident's labial area which was reddened. The resident's upper thighs had reddened areas approximately five inches down the leg from the buttocks. The reddened areas of the buttocks were not blanchable and the resident stated the area was painful when palpated by staff. Review of the facility policy/procedure for "Turning and Repositioning Program" (effective April 2009) revealed the facility would follow the Skin Care Protocols regarding the turning and positioning of residents that may include, but was not limited to, persons with sensory impairment or a Braden Risk Assessment that scored low in mobility and/or sensory perception. Resident #1 was assessed to be at risk for pressure sores related to cognitive impairment and decreased mobility. Interview on August 11, 2010, at 1:45 p.m., with the Licensed Practical Nurse (LPN #1) who was responsible for dressing changes on August 11, 2010, revealed the resident was receiving a protective dressing every three days to the left buttock in the area of the previous pressure sore. According to LPN #1, the resident's dressing had been changed in the early a.m. on August 11,	F 314	3.DON/ETD and UM to complete a random skin audit of 10 residents each week x 2 weeks, then 5 residents weekly x 2 weeks, then 5 residents monthly x 2 months to ensure any area of skin impairment is identified and treated beginning week of 9/16/2010. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	

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F 314	Continued From page 20 2010, and the LPN had not observed any reddened or denuded areas on the resident. LPN #1 confirmed the reddened areas during the observation on August 11, 2010, at 1:45 p.m., were not blanchable and there were four areas of denuded skin. Interview on August 11, 2010, at 4:45 p.m., with LPN #2 revealed LPN #2 had been responsible for the care of resident #1 on August 10, 2010 and August 11, 2010. LPN #2 stated he/she had conducted a skin assessment on August 9, 2010, and the resident had no open or red areas. LPN #2 stated he/she had observed resident #1's skin again on August 11, 2010, after the dressing change at 1:45 p.m., and the resident's buttocks did not appear any different than usual. The LPN stated the resident's buttocks were always red in appearance. Interview with the Director of Nursing (DON) on August 11, 2010, at 2:50 p.m., revealed the nurse responsible for changing the resident's protective dressing on August 11, 2010, did not observe any problem areas that morning. According to the DON, Wednesday was the usual day for the nurse to complete wound treatments. The DON stated the resident was noncompliant with getting out of the wheelchair during the day. The DON had attended the resident's care conferences but the care team had not developed any interventions to address the resident's noncompliance.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube	F 322		

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F 322	Continued From page 21 receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that one (1) resident (resident #12) in the selected sample of twenty (20), who was fed and received medications through a gastrostomy tube (G-tube), received the appropriate treatment and services to prevent aspiration. The resident was to receive nothing by mouth and was observed to enter another resident's room and drink from the water pitcher at the bedside. Staff left a cup of water on the resident's overbed table within the patient's reach. The resident's care plan had no interventions in place to prevent the resident from obtaining fluids. The findings include: Review of the medical record of resident #12 revealed the resident had been admitted to the facility on February 15, 2008, with diagnoses that included pneumonia, cerebral vascular accident, seizure disorder, and dysphagia. Resident #12 had a physician's order dated February 15, 2008, for the resident to have nothing by mouth due to the resident's difficulty swallowing. The resident received nutrition, fluids, and medications via a gastrostomy tube. Review of the speech therapy evaluation dated May 11, 2010, for resident #12 revealed the resident showed difficulty initiating a double swallow with trace amounts of puree	F 322	F322 1.Res. # 12 was placed on 15 minute visual checks when out of bed to ensure that his order for "nothing by mouth" is followed. The physician was notified immediately on 8/11/2010 that resident had drunk water, new orders were obtained and followed, care plan updated to reflect individual needs and physician orders. Resident #12 has had no complication related. 2.A one time audit of all residents with NPO orders was completed by the DON/UM and ETD to identify if any resident had the potential to be affected and the plan of care was appropriate on 9/2/2010.	

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F 322	Continued From page 22 consistency food going to the resident's lungs (silent aspiration). The resident had no cough with the aspiration of food. Review of the annual comprehensive assessment for resident #12 dated April 30, 2010, revealed the resident was assessed to be moderately cognitively impaired, with poor decision-making, and the resident required reminders; cues, and supervision in planning, organizing, and correcting daily routines. The resident was assessed to be able to move about the unit once in the wheelchair. Review of the care plan for resident #12 dated as reviewed on June 24, 2010, revealed the resident had displayed behaviors of entering other residents' rooms to obtain water to drink. The resident had also been assessed to have a history of obtaining water from other residents' rooms and the resident's own sink. The care plan had an intervention dated February 3, 2010, to remind the resident not to drink water. There were no revisions or changes to the interventions on the care plan since February 3, 2010, and no interventions to prevent the resident from obtaining fluids. Review of the Certified Nursing Assistant care plan for August 12, 2010, revealed staff was to report if the resident tried to get fluids. There were no interventions to prevent the resident from obtaining fluids. Observations of resident #12 on August 11, 2010, at 10:30 a.m., revealed the resident had been transported in the wheelchair by a staff member to the hallway. Resident #12 entered another resident's room and drank from the water pitcher in the room. Staff removed the resident from the room after approximately two minutes and placed	F 322	3.ETD re educated nursing staff regarding policy and procedure for following physicians orders, following plan of care, development of comprehensive plan of care and NPO status on 9/07/2010. DON to re educate SSD regarding policy and procedure for addressing behaviors and comprehensive plan of care development by 9/8/2010. DON/ETD and /or UM to review behaviors and all residents with NPO status 5x week x 1 week , then 3 x week x 2 weeks, then 1 x week x 2 weeks beginning week of 9/16/2010 to ensure behaviors are addressed on plan of care, C.N.A care plan is current and correct , focusing on any behavior relating to food/fluid intake. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	

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F 322	Continued From page 23 the resident back into the hallway and removed the water pitcher. Observations on August 11, 2010, at 5:40 p.m., revealed resident #12 to be in bed. The resident's overbed table was located over the resident's lap and within the resident's reach. The overbed table contained two paper cups. One paper cup was empty and the other cup contained approximately 60 milliliters (ml) of clear liquid. The resident stated, "They say I'm not supposed to have water and they leave it here." Interview on August 11, 2010, at 5:45 p.m., with the Registered Nurse (RN) responsible for resident #12 revealed the RN had left the cup of water at the resident's bedside. According to the RN, she had assumed the resident received a meal tray in addition to the gastrostomy tube feeding. Interview with Certified Nursing Assistant (CNA) #1 on August 12, 2010, at 1:15 p.m., revealed CNA #1 had not observed the resident entering other residents' rooms. CNA #1 stated staff tried to keep an eye on resident #12 when the resident was up in the wheelchair. Interview with CNA #2 on August 12, 2010, at 1:20 p.m., revealed resident #12 was not to have water. According to CNA #2, the resident would enter other residents' rooms and drink from the bedside water pitchers and would obtain water from the sink in his/her own room. CNA #2 stated staff checked on the resident frequently when up in the wheelchair but there was no set schedule. Interview with the Unit Manager for the "D" hall on August 12, 2010, at 2:10 p.m., revealed staff had been monitoring resident #12 in the past due to	F 322		

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F 322	Continued From page 24 the resident entering other residents' rooms and drinking the water but discontinued the monitoring since the resident had been doing better. Interview with the Director of Nursing (DON) on August 12, 2010, at 3:45 p.m., revealed resident #12's behaviors of obtaining fluids had been discussed at the care plan meetings but no changes had been made to the resident's care plan. The DON stated the resident was monitored but there was nothing in writing to direct staff on when and how to monitor resident #12.	F 322		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the pre-planned menu was prepared and served to the residents. Observation of the tray line assembly on August 10, 2010, at 5:00-6:30 p.m. revealed the residents did not receive a tablespoon of crumbled bacon as pre-planned by the facility dietitian. The findings include: The evening meal observation on August 10, 2010, at 5:00 p.m. until 6:30 p.m., revealed the	F 363	1. No residents voiced any concerns with the meal on 8/10/2010. 2.Adm/DM and /or SSD to complete a one time interview of 10(ten) cognitive residents to identify any concerns with meals, and /or menus being followed by 9/7/2010. 3.The Registered Dietician to re educate Dietary Service Manager(DM) regarding policy and procedure for following the menus as written by 9/8/2010. Dietary Services Manager to re educate dietary staff regarding policy and procedure for following menus as written by 9/10/2010.	

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F 363	Continued From page 25 facility dietitian had planned a tablespoon of bacon to be served on the potato soup. Observation of the tray line revealed no bacon was available to serve to the residents as planned by the dietitian. An interview was conducted with the facility cook on August 10, 2010, at 5:30 p.m. The dietary cook stated he/she did not cook the bacon to be served to the residents for supper. An interview conducted with the facility Dietary Manager on August 10, 2010, at 6:00 p.m., revealed the Dietary Manager was unaware the bacon had not been cooked.	F 363	Dietary Services Manager to audit at least one meal per day to ensure menus are followed 5 x weekly x 2 weeks, then 3 x weekly x 2 weeks then 1 x weekly x 4 weeks, beginning week of 9/15/2010. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that foods cooked in the Dietary Department were prepared under sanitary conditions. Seven dish racks (7) were observed in the soiled floor of the facility dish room; a bowl of dried, undated macaroni salad was found in the reach-in refrigerator; flies were observed in the kitchen during meal preparation and the meal	F 371	F371 1.Kitchen was cleaned on 8/12/2010 by dietary staff. A deep cleaning of the kitchen will occur by 9/12/2010 by the dietary department. Spills were cleaned immediately, ice	

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F 371	Continued From page 26 service area; the dietary ice scoop was observed to be lying flat on the ice cart; and wet bowls were observed to be available for resident use. In addition, a large bin utilized to store sugar had a clear, sticky spill on the lid. Numerous spills were observed on the stainless steel table during tray assembly on August 10, 2010, at 9:30 a.m. and 5:30 p.m. The findings include: 1. During the initial tour of the dietary kitchen conducted on August 10, 2010, at 9:15 a.m., seven dish racks were observed on the floor of the facility dish room. The floor had food/water spills from soiled dishware, and was unclean. An interview was conducted with the dietary aide washing dishes on August 10, 2010, at 9:20 a.m. The dietary aide stated there was not enough room to store the racks so the racks were stored on the floor. 2. A large bin utilized to store dry stock was observed at 9:25 a.m. on August 10, 2010, to have a clear, viscous, liquid spilled on the plastic lid. An interview was conducted with the facility Dietary Manager on August 10, 2010, at 9.30 a.m. The Dietary Manager stated that he/she was unable to identify the clear liquid. The Dietary Manager further stated the dietary staff was required to wipe/clean all spills promptly after the spill was identified. 3. An unlabeled/undated bowl of macaroni salad was observed in the reach-in refrigerator on August 10, 2010, at 9:30 a.m. The pasta was	F 371	[illegible] scoop was cleaned and covered immediately, and unlabeled open food in refrigerator was discarded immediately. Dishrack was cleaned and sanitized immediately and stored off the floor, a pest company was called and faculty was sprayed for flies on 8/12/2010.No residents were affected by use of wet bowls. The large bin identified was cleaned immediately by dietary staff. 2.Administrator and Registered Dietician to complete a one time audit of the kitchen and storage area to identify whether spills are observed, bowls	

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F 371	Continued From page 27 partially covered by a clear wrap and the edges of the pasta were dried and hard. An interview was conducted with the dietary cook on August 10, 2010, at 9:30 a.m. The dietary cook stated the pasta had been left from the evening meal on August 9, 2010, and should have been dated and completely covered by the clear/plastic wrap. 4. Observation of the tray line assembly on August 10, 2010, at 5:00 p.m., revealed flies in the food preparation/assembly area. The flies were observed to light on clean surfaces of the dish ware and stainless steel tables. An interview was conducted with the Dietary Manager on August 10, 2010, at 5:00 p.m. The Dietary Manager stated the flies had always been a problem in the summer. 5. The dietary ice scoop was observed to be stored on the cart containing a cooler holding ice on August 10, 2010, at 5:30 p.m. The ice scoop was observed to be lying flat on the top shelf of the cart. A storage container for the ice scoop was not observed. An interview was conducted with the Dietary Manager on August 10, 2010, 5:45 p.m. The Dietary Manager revealed the ice scoop was to be stored in a clean/covered container. 6. Forty-eight wet bowls and two trays were observed to be available for resident use on August 10, 2010, at 5:30 p.m. The dietary cook was observed using the bowls as a container for residents' soup.	F 371	are air dried, ice scoop is stored and cleaned per policy and that sanitation and storage is being completed per policy by 9/10/2010. 3.Adminstrator to complete an audit of the kitchen and storage area 5 x week x 1 week then 3 x week x 1 week then weekly x 4 weeks to ensure policy and procedure for kitchen sanitation and storage is being followed beginning week of 9/16/2010. Dietary Services Manager to audit a meal while being prepared and ensure sanitation and storage policy is followed 5 x week x 2 weeks then 3 x week x 2 weeks, then 1 x week x 2 weeks beginning week of 9/16/2010. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	

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F 371	Continued From page 28 An interview was conducted with the facility dietary cook at 5:30 p.m. on August 10, 2010. The dietary cook stated that he/she was aware the resident foods should not be placed in wet containers. An interview conducted with the facility Dietary Manager on August 10, 2010, at 5:45 p.m., revealed the bowls should not have been available to serve residents until they were dry. 7. During the tray line assembly on August 10, 2010, at 5:30 p.m., numerous spills were observed throughout the kitchen on the stainless steel tables. Tomato juice was observed to be spilled on the small stainless table adjacent to the hand sink. An interview was conducted with the Dietary Manager on August 10, 2010, at 6:00 p.m. The Dietary Manager stated the dietary staff was required to clean up spills at the time the spill occurred.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	F431. 1. The refrigerator at Nurses Station #2 was replaced immediately on 08/12/10. The expired medication was immediately removed and discarded on 8/12/2010 The medication that was in the nurses pocket was removed and stored properly 2.The ETD reeducated licensed nursing staff on 9/04/2010 in	

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F 431	Continued From page 29 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to store all drugs and biologicals in locked compartments, under proper temperature controls, and to dispose of expired medications properly. Observation revealed expired Tylenol and urine culture vials available for resident use. In addition, resident medication for one (1) of twenty (20) residents was being stored in a licensed practical nurse's (LPN) pocket. Further, the temperature of the medication refrigerator at nurses' station #2 was observed to be at an inappropriate temperature for medication storage. The findings include:	F 431	regards to the proper temperature that medication is to be stored when it needs to be refrigerated, policy for medication storage was reviewed, (36-46 degrees Fahrenheit) , storage of discontinued med and meds for discharged residents. All meds are to be sent back to pharmacy immediately when a resident is discharged. If they can not be sent back immediately, they are to be stored separately and away from resident use. The DON and ETD reeducated licensed nursing staff that nothing is to be stored in the Emergency Kit cabinet, but the box itself. On 9/4/2010, the ETD and DON reeducated all licensed nursing staff that all meds are to be given as soon as they pulled up. No medication is to be transferred or stored away from the medication cart. ETD reeducated all licensed nursing staff regarding checking for expired meds and supplies and discarding immediately, and not to carry meds in pockets. 3.Unit Manager or designee will check med refrigerator temperature every shift for one month starting the week of 9/16/10 for appropriate temperatures and record on a calendar. Then they will check temps of the refrigerator daily on the 11-7 shift on-going to assure proper temp is maintained. A one time audit was done on 8/30/2010	

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F 431	Continued From page 30 1. Observation of the nurses' station #2 medication storage area revealed the refrigerator temperature was 50 degrees Fahrenheit. Review of the facility's policy on medication storage dated May 10, 2010, revealed the facility should ensure that medications and biologicals are stored at their appropriate temperature according to the United States Pharmacopeia guidelines for temperature ranges. According to the policy, medications requiring refrigeration should be stored at 36-46 degrees Fahrenheit. 2. Further observation of the nurses' station #2 medication storage area revealed Tylenol 325-mg tablets were available for resident use and were observed to have expired on May 15, 2008. In addition, Tylenol 325-mg tablets were observed in a box with a resident's name in the same medication storage cabinet. Observation revealed the Tylenol had expired on May 16, 2010, and the resident was no longer a resident of the facility. Further review of the facility's medication storage policy revealed the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other applicable law. In addition, the facility should ensure that medications and biologicals for expired or discharged residents are stored separately, away from use, until destroyed or returned to the provider. Interview with the Unit Manager on August 12, 2010, at 1:20 p.m., revealed the facility did not have an effective system for ensuring expired drugs/biologicals were not available for resident use. The Unit Manager stated it was the nurse's	F 431	of all facility med refrigerators for any expired meds. They also will check all stored meds in the refrigerator for expiration dates monthly and record. A one time audit or all lab vials was done on 8/30/2010. Any expired vial or supplies were discarded. Beginning the week of September 16, 2010 Unit Manager or designee will check monthly for expiration dates and record. The EDK cabinets were also audited on 8/30/2010 to assure that nothing was stored in the cabinet except the EDK box itself. Beginning the week of 9/16/10 Unit Manager will check EDK cabinet weekly for 1 month to ensure that nothing is store in these but the EDK box. Unit Manager or designee will follow up on all discharged residents to ensure that all medication is returned immediately. Pharmacy representative to complete a one time medication pass audit by 9/22/10 to ensure all medications are stored per policy, that no medication are carried or stored in pockets and that medications are stored in refrigerator at temperatures per policy. DON/UM and /or ETD to complete 2 random med pass audits, every week for 2 weeks then 1 time a week for 2 weeks to ensure medications are not stored in Licensed Nurses	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	185173	A. BUILDING _____ B. WING _____	C 08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 31 responsibility to pull and dispose of the medications after a resident leaves the facility and to dispose of expired medications when the staff "had time." 3. Observations of resident #7 on August 10, 2010, at 10:55 a.m., 11:05 a.m., 11:23 a.m., 11:42 a.m., 11:48 a.m., 11:55 a.m., 12:03 p.m., 12:12 p.m., 12:20 p.m., and 12:46 p.m., revealed staff did not administer Oasis moisturizing mouth spray as ordered by the resident's physician three times a day before meals. Interview with resident #7's primary LPN on August 11, 2010, at 5:10 p.m., revealed the LPN had carried the resident's Oasis moisturizing mouth spray in the nurse's pocket on August 10, 2010, in anticipation of administering the medication to resident #7 at lunch time. Further review of the facility's policy for medication storage dated May 10, 2010, revealed the facility should ensure that all medications and biologicals, including treatment items, were securely stored in a locked cabinet/cart, or locked medication room. Interview with the Director of Nursing (DON) on August 11, 2010, at 3:34 p.m., revealed all medications should be stored on the medication cart, not in staff members' pockets. Further interview revealed the DON did not monitor to ensure that medications were stored and administered per policy. Interview further revealed the facility recently in the last month started an education director training that observes the medication pass to ensure proper administration and storage, however, the LPN carrying medication in her pocket had not been	F 431	/KMA's pocket and /or stored off the med cart beginning week of 9/22/10. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	

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F 431	Continued From page 32 observed during medication pass as part of the new training.	F 431		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective pest control program so the facility was free of pests. Flies were observed in the facility from August 10-12, 2010. The findings include: Observations conducted during the initial tour on August 10, 2010, at 9:05 a.m., revealed two flies in room C-12 and one fly in the D Wing hallway. Additional observations conducted in the kitchen during the initial tour on August 10, 2010, at 9:15 a.m., revealed two flies in the kitchen. Observations conducted during the supper meal on August 10, 2010, from 5:00 to 6:00 p.m., revealed one fly in room A-5, three flies in room C-12, and three flies in the kitchen. Observations conducted on August 11, 2010, at 1:30 p.m., revealed two flies in the hallway near the C/D Wing nurses' station. Observations conducted on August 11, 2010, at 3:15 p.m., revealed three flies on the C/D Wing	F 469	1. The facility immediately called a pest control co. and a representative came in on 8/12/10 and sprayed outside as well as around the building for flies. The facility smoke area was moved farther away from the doors outside the kitchen are to try to cut down on the chances of flies coming into the building. 2. All housekeeping staff were reeducated on 9/10/2010 by the Administrator and Maintenance Director in regards to cleaning up garbage and litter immediately , especially in resident room areas, to keep flies to a minimum. The facility pest control co will spray at least weekly beginning 9/16/10 for flies with emphasis on the outside areas around the kitchen, the dumpster area, and the patio and exit doors. Facility staff will observe for flies daily and address them immediately when seen. All housekeeping staff have fly swatters on their carts as well as them being located through the building to better control flies.	

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F 469	Continued From page 33 hallway near the nurses' station. Additional observations revealed resident #21 to swat at flies and resident #22 was observed to have one fly crawling on the resident's hand and one fly crawling on the resident's leg. A group interview conducted with eight interviewable residents on August 11, 2010, at 4:00 p.m., revealed the facility frequently had flies in the building and in resident rooms. An interview conducted with the Housekeeping Supervisor on August 11, 2010, at 2:00 p.m., revealed that the housekeeping staff had fly swatters and additional fly swatters were kept in the resident dining room. The Housekeeping Supervisor was not aware of any additional interventions utilized to control flies. An interview conducted with the Maintenance Director on August 12, 2010, at 11:00 a.m., revealed a pest control company treated the facility monthly and as needed for pests. However, the pest control company did not treat for flies. A review of the facility pest control service agreement dated March 11, 2009, revealed the agreement did not provide coverage for control of flies.	F 469	3. Beginning the week of 9/16/10, a log will be kept when flies are observed and the pest control co. will spray accordingly. Starting the week of 9/16/10 he will spray every week for the next month, and then monthly after that. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	F514 1. Resident #16 was a deceased resident, and was reviewed in a closed record. 2. on 9/5/2010 the ETD reeducated all licensed staff on any change in condition, the MD and resident responsible party must be notified	

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F 514	Continued From page 34 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain accurately documented clinical records for one (1) of twenty-two (22) sampled residents (resident #16). Resident #16 sustained a significant change in medical condition on June 16, 2010, and the facility failed to document that the physician was notified of the changes in the resident's medical condition. The findings include: Review of the facility policy regarding physician notification revised in June 2009 revealed staff was required to immediately notify the physician and family or legal representative if there was a significant change in a resident's condition, regardless of the time of day/night. Review of the medical record for resident #16 revealed the record contained documentation signed by the legal guardian on July 1, 2008, for "Do Not Resuscitate." Review of the nurse's notes dated May 27, 2010, at 12:30 p.m., revealed resident #16's oxygen saturation was noted to be 85 percent, the resident's attending physician was notified of the change in the resident's physical condition, and new orders were received to transfer the resident to the	F 514	and documented in the resident clinical record. 3. Beginning the week of 9/16/10 Unit Manager will do a 24 hour look- back on all charts every day for one week, then 3 time weekly for 1 week then 2 times a week for 1 week, and then weekly for 1 month. They will monitor that all changes in condition were reported to the physician and responsible party and this was documented in the clinical record. As a further check, any clinical records reviewed in the daily Clinical Meeting will also be reviewed by the DON or designee. 4.Quality Assurance Committee to review audit findings and revise plan as necessary weekly x 4 weeks then monthly beginning week of 9/23/2010. 5.Date of Compliance 9/23/2010.	

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F 514	Continued From page 35 Emergency Room at the local hospital. The resident was admitted to the hospital with a diagnosis of pneumonia and was discharged back to the facility on June 4, 2010. On June 12, 2010, at 2:30 p.m., the resident's vital signs were recorded as: blood pressure - 124/70, temperature - 98.6 degrees Fahrenheit, pulse - 68, and respiratory rate of 24. Although the resident was nonverbal, according to the nurse's notes, resident #16 opened the eyes at times, had non-labored respirations, and had an oxygen saturation of 92 percent on three liters of oxygen. On June 16, 2010, at 11:20 p.m., nurse's notes revealed resident #16 was observed by facility staff to be pale, cool/clammy to touch, and the resident's nails beds were cyanotic. The resident was noted to have Cheyne-Stokes respirations and was suctioned by staff with thick yellow sputum observed. Staff obtained an oxygen saturation for resident #16 which was documented as 58 percent. Staff documented that the Power of Attorney for resident #16 was notified of this change in the resident's medical condition; however, there was no documentation the attending physician was notified of this significant change in the resident's medical condition. Interview on August 12, 2010, at 3:30 p.m., with the nurse (an LPN) who documented the entry in resident #16's medical record on June 16, 2010, at 11:20 p.m., revealed that although the nurse reviewed the documentation in the resident's medical record, the nurse could not remember if the physician had been notified of the change in resident #16's medical condition. The nurse voiced understanding of the facility policy and stated staff was required to notify the physician	F 514		

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F 514	Continued From page 36 immediately when there was a significant change in a resident's condition. Interview with the Corporate Nurse Consultant and the Director of Nursing on August 12, 2010, at 3:00 p.m., revealed staff was required to immediately notify a resident's attending physician when there was a significant change in a resident's condition even if the resident was a "Do Not Resuscitate." The Corporate Nurse Consultant further stated in interview on August 12, 2010, at 3:40 p.m., when a resident's oxygen saturation dropped to 58 percent this would be considered a significant change in a resident's medical condition. Interview with the Unit Manager on August 12, 2010, at 4:55 p.m., revealed the Unit Manager was present when the nurse (an LPN) notified the physician of the change in condition for resident #16 on June 16, 2010, at 11:20 p.m. The Unit Manager stated the LPN failed to document that the physician had been notified.	F 514		

Received Time Sep. 4. 2010 2:50PM No. 2527

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Southern Enforcement Branch

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on August 12, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. This deficient practice affected four (4) of nine (9) smoke compartments, staff, and approximately eighty-eight (88) residents. The facility has the capacity for 93 beds with a census of 89 on the day of the survey. The findings include: During the Life Safety Code tour on August 12, 2010, at 2:30 p.m., with the Director of Maintenance, a linen cart was observed not to be in use and unattended in the D Wing corridor of	K 072	K72 All linen carts will be stored in the linen closet when not in use. They will not be stored in hallways nor block any means of egress. The maintenance director and administrator reeducated the housekeeping and nursing staff on storage space requirements, and that carts of any kind can not be kept in the hallways when not in use. Members of the facility Safety Committee will audit the halls daily to assure compliance with this requirement. Any findings will be corrected immediately. These findings will also be reviewed in the monthly Safety Committee meeting and recommendations made as necessary. Completion Date September 23, 2010	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gail Spurgeon	Adm	9/4/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

09/04/2010 SAT 14:58 FAX 606 677 1925 Sunrise Manor 039/072

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K 072	Continued From page 1 the facility. An interview with the Director of Maintenance on August 12, 2010, at 2:30 p.m., revealed it was determined that staff had to travel too far to get linens so the linen carts were stored in each of the four resident corridors. The Director of Maintenance was aware the linen carts should not be stored in the corridors. Corridors are intended for means of egress, internal traffic, and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the hand rails by occupants of the building when needed.	K 072		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected five (5) residents. The facility has the capacity for 93 beds with a census of 89 on the day of the survey. The findings include: During the Life Safety Code tour on August 12, 2010, at 3:15 p.m., with the Director of Maintenance, a nebulizer, oxygen concentrator, and suction machine were observed to be plugged into a multi-outlet adapter (power strip) in resident room D-11. Generally power strips with surge protection may be used for resident TVs,	K 147	K 147 The medical equipment in rooms A-3, A-9, B-3 and B-4 is now plugged directly into the outlet in each room. The power strips in each room identified are now only used for non-medical equipment. The Maintenance Director is reviewing all rooms to ensure there are enough outlets (receptacles) for everything needed in the rooms. The are in process of adding receptacles as needed to adequately meet the needs of each room.	

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K 147	Continued From page 2 computers, radios, etc., on an as-needed basis but not to be used with medical equipment to help prevent against electrical shock. An interview with the Director of Maintenance on August 12, 2010, at 3:15 p.m., revealed the Director of Maintenance has tried to reduce the amount of power strips being misused in the facility. During the survey power strips were observed to be in use with medical equipment in resident rooms A-3, A-9, B-3, and B-4. Reference: NFPA 99 (1999 Edition). 3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	All staff were reeducated that all medical equipment must be plugged directly into the receptacle, and not the power strips. Members of the facility Safety Committee will randomly review rooms daily to ensure compliance. Any deficient practice will be corrected immediately. Their finding will be reviewed in the monthly Safety Committee Meeting for recommendations. Completion Date September 23, 2010	

09/04/2010 SAT 14:59 FAX 606 677 1925 Sunrise Manor 041/072